Trainee nursing associates: a landmark innovation?

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Statista (2018) report numbers of nurses employed in the UK have increased from 501,000 in 2010 to 659,000 in 2017, yet there remains demand for extra nursing staff to meet current workloads. Tissue Viability Services are required to effectively and safely manage a range of healthcare settings and have not always seen their patient:staff ratio rise in line with the growing work load. In England, the Trainee Nursing Associate (TNA) — a new role — was designed to support Registered Nurses deliver hands-on care for patients. Health Education England (HEE, 2016) published an outcomes-based framework curriculum for TNAs, providing seven key domains at acadamic Level 5, which each TNA would be competent in following completion. The seven key domains are:

- **Domain 1:** Professional values and parameters of practice
- **Domain 2:** Person-centred approaches to care
- **Domain 3:** Delivering care
- **Domain 4:** Communication and interpersonal skills
- **Domain 5:** Team working and leadership
- **Domain 6:** Duty of care, candour, equality and diversity
- **Domain 7:** Supporting learning and assessment in practice.

HEE (2016) state that *"At level 5, the qualifying nursing associate will have the qualities necessary for working in situations that require personal responsibility and decision-making. They will be able to undertake further training, develop existing skills and acquire new competencies."*

The programme is intended as a standalone Level 5 qualification, but also provides the basis for further, lifelong study and progression into higher-level qualifications (HEE, 2016). The two-year programme equates to a total of 3,375 hours of work-based and academic learning with 675 hours in placements across three health and care settings: hospital; at home; and close-to-home settings. Traverse (2018) in their review of the TNA programme stated the aims of the programme are to:

- Support the career progression of care assistants
- Increase the supply of nurses
- Enable nurses to undertake more advanced roles.

The HEE Nursing Associate Curriculum (2016) identifies wound care and tissue viability as a key skill of these TNAs:

"The nursing associate will be required to have a nationally standardised, higher level of knowledge and skills to care for complex wounds. To enable the registered nurse to support individuals with the most complex, unstable wounds, the nursing associate will be required to bridge the gap between the simple wound and the most unstable. These situations carry risk. The wrong judgement can mean that a healing wound deteriorates and a deteriorating wound is not appropriately assessed and the situation acted upon in time."

According to the Nursing and Midwifery Council (NMC, 2018) there are 2,000 student nursing associates at 35 test sites across England and a further 5,000 new starts planned for 2018 and 7,500 in 2019. The first TNAs will qualify and apply for registration with the NMC from January 2019, joining the new nursing associate part of the register — they will not be registered as nurses. Will TNAs be the landmark innovation Tissue Viability Services need right now? *Karen Ousey*

1. The role of TNA aims to bridge the gap between Healthcare Assistants and Registered Nurses. What are your initial thoughts and feelings regarding this new role?

SH: Having qualified as a nurse just over 30 years ago, the notion of a role which straddles the responsibilities of a Healthcare Assistant and a Registered Nurse is not new. For example, the role of Cadet Nurse in the 1960s and 1970s was designed as a stepping stone for entry into nurse training. Those who followed this route were great proponents of this approach which they argued provided an authentic foundation for nurse training. The Nursing Cadet programme has seen a resurgence in healthcare in recent years (https://www.healthcareers.nhs.uk/); in fact the 'apprenticeship' route as a work-based training model has been shown to

be effective in health and social care (Kirby, 2015).

FD: This is not a new concept in nursing. If the correct training is in place this role could be beneficial to both nursing and, specifically, to tissue viability services. It does require careful consideration of the scope of practice for the TNA in tissue viability.

ZM: My initial thoughts centred around the fact that the TNA will be a regulated role, and as such, the document published in October 2018 outlining the standards of proficiency for nursing associates, is of key importance from my perspective (NMC, 2018). It is clear that much thought has gone into the development of this role, and given that there is a significant shortfall in trained nurses to care for an ever-increasing number of users of the health service, this role is a welcome one. The issue that is of significant importance to me is the education and training that the TNA will undertake, as this will provide reassurance of the competencies achieved by the TNA before registration. Furthermore, the scope for role advancement, through further education and training is of importance also, to ensure that the role will be enabled to progress in response to ever-changing healthcare demands.

LC: With the correct training/education/skills/support, TNAs could prove very beneficial. I think that it all comes down to the correct training, not only training undertaken for their qualification, but continued training and education throughout their role within tissue viability.

2. With referrals to Tissue Viability Services increasing, will the TNA role be beneficial to your team?

SH: The TNA is a described as a 'support role' (NHS Health Education England, 2017) therefore it provides a good opportunity for integration with existing Tissue Viability Services assuming there will be an agreement about the required levels of competence. There are existing support roles such as those undertaken by Healthcare Assistants who have taken a hands-on function in wound care (Lloyd-Jones and Young, 2005), therefore, there is a precedent for integrating TNAs in service provision, albeit at a different level. However, there will be need to careful thoughts with regards to the boundaries of responsibilities to ensure safe practice. Yet this may prove challenging as there is an ongoing debate regarding the required level of wound management education and skills to undertake wound care across pre- and post-registration education (Holloway et al, 2018).

FD: I think this would depend on the type of service, i.e. if a leg ulcer clinic it may be possible that the TNA would be able to help with dressings and bandaging after both training and undertaking relevant competencies.

ZM: Within the healthcare setting in Ireland, as with other healthcare settings, there is an increasing demand on Tissue Viability Services to provide care to individuals with increasingly complex wounds. Indeed, it is estimated that annually in Ireland 4.47% (n=204,783) of the population are affected by a wound (Gillespie et al, 2016). Therefore, in the face of high patient loads, the added dimensions of the Advanced Nurse Practitioner/Clinical Nurse Specialist role in tissue viability, including research, audit and education are challenging to achieve. Once the Advanced Nurse Practitioner/Tissue Viability Nurse (TVN) has established an accurate diagnosis, and an appropriate plan of care, the delivery of this care plan could be achieved by another member of the healthcare team, once s/he has been trained and is competent to do so. This would enable the fulfilment of all the elements of the tissue viability role, while ensuring safe delivery of care to patients.

LC: The role of the TNA would be beneficial to my team. Within my team, I have Band 3,4 and Registered Nurses all working as Link nurses. Band 3,4, and Registered Nurses all receive the exact same training regarding tissue viability, and are expected to provide wound/pressure ulcer care for patients. Healthcare Assistants and Assistant Practitioner are already performing these tasks within my workplace, and they provide huge support to me in my TV Lead role. TNAs, therefore, could also — with the correct training.

3. The curriculum states: "The nursing associate will be required to have a nationally standardised, higher level of knowledge and skills to care for complex wounds..." Do you think this is appropriate for a TNA?

SH: Currently, there are no nationally agreed standards for the care of individuals with complex wounds, however, the introduction of a National Wound Care Strategy by the Academic Health Science Networks (AHSN) (Wounds UK, 2018) may be helpful in proposing the required benchmarks. It will be important for this group to explore what defines *'higher level knowledge and skills'.* The Quality Assurance Agency (QAA) framework for level 5 states that: *"holders of qualifications at this level will have developed a sound understanding of the principles in their field of study, and will have learned to apply those principles more widely" (QAA, 2014).* This does not necessarily convey a requirement for *'higher level,'* which may lead to a confusion for educators and practitioners in terms of implementing the TNA curriculum.

FD: My initial response is a higher level of knowledge and skills to whom or what; this needs clarifying. How is this 'higher level of knowledge and skills' set to be assessed? In addition, will it be decided locally or nationally to what part a TNA will play in wound assessment, on-going wound

management and subsequent evaluations of this management. The use of the term 'complex wound' is interesting, because a complex wound can be defined in many ways depending on the origin of the wound; an open abdomen, for example, is extremely complex and would this be appropriate for a TNA to assess and decide management of? All of the above needs clarification in the domain of tissue viability to ensure the TNA is not put into situations where they may be asked to operate out of their scope of practice.

ZM: Clarity will be required pertaining to what is meant by a *'higher level of knowledge and skills...'* and how this will be developed, assessed and monitored. None the less, there is evidence from the literature pertaining to the impact of the physician associate in terms of clinical outcomes (Halter et al, 2017). Given the debate that took place when the concept of Physician Associate was first mooted, whilst acknowledging that a different skill set is required for the TNA, it is evident that once adequate training, mentorship and supports are put in place, individuals can embrace new roles previously unheard of in clinical practice. I think that fundamentally, it is possible to develop skills in the TNA such that with the right set of competencies and clear guidance and supports, they will become a valuable contribution to the team involved in managing individuals' with complex wounds.

LC: I feel a little split regarding this question. I see Band 3,4, and Registered Nurses caring for complex wounds daily. However, I — as the TV Lead — am on the ward to offer help and support if required. I would be a little uneasy regarding the TNA being asked to care for complex wounds without experience and appropriate support on hand. For me, a non-specialist qualification would not be sufficient to prove that the TNA had the required expertise. I would need to build confidence and trust in the ability of that person. Tissue viability is a specialism that is only acquired by working within it and gaining specific qualifications in that field. Also, are we simply concerned with complex wounds? If a category 1 pressure ulcer is not treated correctly, this can also be of detriment to the patient.

4. Within the curriculum, there is a list of areas beyond the parameters of practice for the TNA role. These include: "i) acting autonomously to change the prescribed plan of care
ii) acting autonomously in situations where there may be limits to confidentiality — for example, in safeguarding situations iii) decision to make specialist referrals iv) decisions to share information across multiagency boundaries
v) interpretation and resolution of risk issues (they must be able to identify risk and halt practice if necessary)
vi) decision to discharge an individual from a service
vii) administering medicines under a patient group directive
ix) prescribing medicines."
In your opinion do these conflict with the areas of the curriculum that highlight the TNA will care for wounds?

SH: The NMC states that the standards of proficiency for TNAs will be aligned with the new standards for Registered Nurses with the intention of facilitating a smooth progression for TNAs wishing to progress to a Registered Nurse (NMC, 2018). One of the principles of the curriculum is to develop TNAs to work independently within defined parameters under direction from a Registered Nurse (NHS Health Education England, 2017), however, the way in which the curriculum has been operationalised appears to reflect a higher level of competence than would be expected for a level 5. It is therefore vital that there is a mechanism for ongoing consultation and evaluation to explore this disparity.

FD: Again, I find this question difficult to respond to without clarification and examples that are pertinent to wound management and tissue viability as a specialty. For example the discharging from a service; this is a significant undertaking in a setting of a dressing or wound review clinic. In my organisation the wound review service is nurse consultant led, and the discharge of patients from this service is undertaken only by a Band 7 or the nurse consultant for tissue viability.

ZM: The clarity provided in the definition of the sope of practice of the TNA, in addition to the specific areas beyond the the parameters of practice for the TNA are important. This will ensure that the individual TNA will be aware of what it is they can and cannot do within their scope of practice. Further, this is also a core element of the nursing profession. However, rather than seeing this as a limitation, it should be seen as a clear starting point, as the HEE (2016;19) also state that *'...They [the TNA] will be able to undertake further training, develop existing skills and acquire new competencies'* Given that Welsh (2018) identified a consistent lack of knowledge among nurses pertaining to wound care within the published literature, the development of competency in this field continues to be an important issue. Could it be that the role of the TNA and the scope for role expansion is an opportunity rather than a threat?

LC: Yes, I believe it does. These situations would require autonomous decisions at that moment. If the TNA is being equipped with the knowledge and skills to care for complex wounds, and they have gained sufficient skills and experience, how are they supposed to put this into practice if making autonomous decisions is beyond their parameters of practice? We would be working within the realms of blurred boundaries once again, which happens so often with HCAs.

5. Does the TNA role have the potential to improve outcomes for Tissue Viability Services?

SH: If the TNA role within Tissue Viability Services is carefully aligned to form a clear strategy then there is no reason why individuals functioning at this level should not be able to contribute to quality service improvement projects. In fact, it is often argued that there needs to be more evidence for how Tissue Viability Services improve outcomes, therefore, having a TNA could help to re-distribute responsibilities to allow TVNs more time for quality improvement activities. However, careful consultation with key stakeholders, i.e. patients, relatives and carers, will also be necessary to manage expectations.

FD: Every role has the potential to enhance Tissue Viability Services. However, in my opinion, a national agreement of what the actual scope of practice for the TNA role would be in tissue viability would be necessary and essential.

ZM: At its essence, Tissue Viability Services aim to provide, timely, seamless, appropriate, person centred wound care, to the population whom it serves. To do this effectively and efficiently, there is a need for a team approach, with each member of the team practicing to the maximum of his or her competency. Further, Tissue Viability Services need access to other members of the multidisciplinary team, in order that all dimensions of the patients' needs can be addressed and managed appropriately (Moore et al, 2014). It is clear that no two members of the team will have the exact same skill set, thus the Tissue Viability Team will benefit from inclusion of individuals with the right depth and breadth of skills, so that the team can function well. The TNA could contribute to enhancing the outcomes for Tissue Viability Services, once their role is clear, unambiguous, well understood by the team members and providing that they are seen and valued as a central member of the team.

LC: Yes, I believe so. A person who has been trained to the required standard, and continues to receive training throughout his/her role, would be of huge benefit to the TVNs and patients alike. The training of the Registered Nurses, Health Care Assistants and Assistant Practitioners to the same standard within my workplace has provided evidence of improved outcomes for the patient, the service and the organisation. Hopefully the training would equip TNAs with enhanced skills that would serve as a solid base on which to build their tissue viability knowledge and skills.

6. Does this role present any threats or challenges to the Registered Nurse or tissue viability as a speciality?

SH: The introduction of a new role will no doubt lead to a discussions about resource (re-)allocation and also boundaries of responsibilities between healthcare practitioners and service managers, therefore it will be important for those working within a TV role to anticipate any potential areas of conflict in order to devise a pro-active strategy to mitigate these. This approach should be closely aligned to the National Wound Care Strategy in England which perhaps needs to offer some suggestions for defining roles and responsibilities in order to provide some leverage for practitioners to negotiate roles and responsibilities.

FD: I think this new role will require careful evaluation before we can assess its impact on both nursing and the speciality of tissue viability.

ZM: As the role of the nurse becomes even more specialised, there is a corresponding evolution in the roles of other health care workers in order to ensure that patient needs are met within the clinical arena. As with all evolution, role ambiguity can arise during the period of transition. A systematic review by Spilsbury and Meyer (2001) identified within the existing research evidence of the time that Registered Nurses make a difference to patient care, however, given that nursing is every evolving it is difficult to really quantify the precise contribution. Howver, role clarity is at of the essence and the Royal College of Nursing, the International Council of Nurses and the World health Organisation provide significant insight into the definition of nursing and the role of the nurse. As with the evolution of advanced practice roles in nursing, which would not have been so successful without the support and encouragement of other members of the healthcare team, the role of the TNA needs to be viewed positively. Patients have the right to receive care that is appropriate to their needs and is delivered in a timely manner. This care should be delivered by a competent, proficient practitioner and once the TNA develops the necessary competency, the role should be seen as one that augments nursing/tissue viability, rather than competes with it.

LC: No, the role does not present any threat to Registered Nurses or TVNs. The Registered Nurses within my workplace have embraced our way of working, and there is mutual respect between the grades. I, as Tissue Viability Lead, certainly do not feel threatened by our Healthcare Assistants and Assistant Practitioners performing wound/pressure ulcer care. The TVN is a specialist. Within the NHS, TVN posts require the applicant to hold a registration and pin number, and this would prevent any TNA from applying for that post, as they would not be on the nurses register. Also TVNs now are encouraged to study for a Masters Degree, which, within some job descriptions, is compulsory. This may not be an option for some TNAs, as with some Registered Nurses. However, within another setting, perhaps Nursing Homes or Hospices, where banding and roles are perhaps not so rigid, the TNA may find a lead role within tissue viability. The TVN role is multi-dimensional, part

manager, part educator and part nurse, and an individual with the basic TNA qualification would not pose any threat to the TVN. However, if registration and pin number restrictions to job descriptions were to change within the NHS, and TNAs continued their specialist education and training within tissue viability, there could possibly be a pathway for TNAs to rise up through the ladder of tissue viability. This would obviously be reliant on the TNA holding the same qualification and experience in tissue viability as other TVNs.

Challenges, yes. The challenges would be to support and monitor the TNA, which may be time consuming and labour intensive for an already stretched service. However, as the TNA gains more knowledge and skills, the Registered Nurses and TVNs will gain more trust and confidence in the TNA's abilities, which should alleviate this problem. Other challenges may come from the acceptance of someone of a higher-grade taking advice from someone of a lower grade, regardless of their qualifications and experiences in tissue viability. I think that it would be unproductive and unjustified to feel threatened by the TNA role. We should embrace the opportunity to have individuals who wish to join the Tissue Viability Service and offer support and guidance as required, helping to shape the future Tissue Viability Service in a way that is in the best interest of the patients. WUK

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